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State of Washington
Health and Recovery Services
Administration

Review of
Organizational Realignment

MERCER

Government Human Services Consulting



Marsh & McLennan Companies

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1

EXECUTIVE SUMMARY

In July 2005, Secretary Robin Arnold-Williams formally announced a restructuring of the Department of Social and Health Services (DSHS) to create the Health and Recovery Services Administration (HRSA). The new organization combines seven existing Divisions of the DSHS Medical Assistance Administration (MAA) with the Division of Alcohol and Substance Abuse (DASA) and the Mental Health Division (MHD) from the former Health and Rehabilitation Services Administration.

Prior to this change, MAA was in the midst of realigning operations to promote more interdependence among its Divisions, leverage its resources, improve efficiency and create clear lines of accountability, and assure appropriate checks and balances between Divisions. MHD also underwent an organizational analysis to assess how it could improve quality of care, efficiency, and accountability.

HRSA engaged Mercer Government Human Services Consulting, the government specialty group within Mercer Human Resource Consulting (Mercer), to conduct an organizational and operational review of the newly established HRSA. The consulting review included the following tasks:

- Provide an independent assessment of the strength of the proposed HRSA organization, including the realignment underway at MAA, through a document review and interviews of key staff within HRSA and the Divisions.
- Identify administrative efficiencies while preserving programmatic strength in alcohol and substance abuse, acute physical health care, and mental health care.

This report presents the professional opinions of Mercer, based on the objectives outlined above, the materials provided for review, interviews with representatives from HRSA, MHD, and DASA and Mercer's many years of experience working with Medicaid and other government sector health care organizations. While the review conducted was not intended to

be all encompassing, we believe it is thorough and presents solid recommendations for the HRSA realignment.

FINDINGS AND RECOMMENDATIONS

MAA Realignment

- Overall, the proposed organizational alignment of MAA appears to support the objective for greater interdependence among the Divisions and yet, provides appropriate checks and balances that will promote accountability and efficiency.

HRSA Restructuring with DASA, MAA, and MHD

- The restructuring of HRSA to include DASA, MAA, and MHD offers the opportunity to address administrative efficiencies and develop policy and integrated treatment approaches for physical, mental health, and substance abuse disorders.
- The importance of maintaining strong programmatic identities for DASA and MHD, as planned by HRSA, will provide a structure that supports the unique needs of state residents with alcohol, substance abuse, and/or mental disorders. Stakeholders will continue to have points of contact with these Divisions and staff with specialized skills and experience can more likely be retained and developed, and new talent recruited.
- To provide for increased efficiencies related to DASA and MHD, some operational aspects of these agencies could be shared among DASA, MAA, and MHD under the new HRSA umbrella. This “shared services” model implies that certain Divisions, such as Finance and Information Technology, are responsible for providing services that are used by *all* Divisions. Each Division retains appropriate control over various aspects of shared services.
- Under a shared services model, establishing priority among competing needs is necessary. Mercer recommends the Office of the Assistant Secretary at HRSA provide this function.
- Organizational structures are most supportive when all departments or divisions share a common mission and vision, and support the same core competencies. The Division of Disability Determination Services does not appear to fit well in the new HRSA. Consideration should be given to moving this to an agency separate from HRSA.

Office of the Assistant Secretary

Five key areas under the Assistant Secretary of HRSA would provide shared services:

- Communications – coordination of internal and external communications, including management of the intranet.
- Legislative & Government Relations – coordination of legislative initiatives, research and relationships with the Legislature, Tribes, and other government agencies.

- Human Resources (HR) & Legal Services – adding “Human Resources” to the office of Legal Services title provides a focal point for HR functions and the interface with the DSHS HR office. HR functions will be especially important to implement the cultural shift in moving toward an interdependent administration while “folding” in two new Divisions. Legal Services will include oversight of administrative hearings, regulations, contracts management/coordination with DSHS and other legal issues. Mercer recommends the Office of the Assistant Secretary function as the central interface with DSHS, as well as be the general gatekeeper for all contracts within HRSA.
- Quality Management/Chief Medical Officer – oversight of quality management and monitoring activities throughout HRSA, including establishing a HRSA-wide Quality Management (QM) Committee and a formal QM Plan. Mercer recommends this position report to the executive branch to address administration-wide quality management goals and provide the authority to execute the QM Plan.
- Internal Audit – independent appraisals of all HRSA programs, contracts, divisions, and individuals receiving funds from HRSA. Mercer recommends this function report to the executive branch due to the potential scope and sensitivity of Internal Audit’s responsibilities.

The Divisions would retain some shared services with respect to functions managed at the Assistant Secretary level. These include:

- Procurement – All procurements require coordination and approvals through the DSHS Central Contract Service Office. Major Procurements, such as Regional Service Network (RSN) services or Health Plans – the program specialty Division, (e.g., the Mental Health Division, Division of {Medical} Benefits and Care Management, Division of Alcohol and Substance Abuse) should continue to assume lead roles within their specialties. The Divisions should partner with Contracts Management and other experts throughout HRSA, such as finance and technology, to develop a best-in-class team approach to procurement.
- Contract Monitoring – Mercer recommends that contract monitoring occur in the Division that has the core competencies in acute health, mental health or substance abuse. Over time, this recommendation could be re-evaluated to see if further efficiencies could be gained by centralizing some contract monitoring functions.
- Mercer also recommends modifying the name of the Division of Benefits and Care Management to the Division of *Medical* Benefits and Care Management to provide a clear focus for physical health care policy and operations and to provide parity among the Mental Health and the Alcohol and Substance Abuse Divisions.

Division of Finance & Rates Development

Mercer recommends that budgeting, finance, accounting, rate setting, and fee-for-service (FFS) rate development be supported through a shared services model and centralized in the Division of Finance & Rates Development. A fiscal or budget representative could remain in

MHD and DASA and function as a liaison to the Division of Finance & Rates Development, offering MHD and DASA a central point of contact and someone who understands issues unique to each of their divisions. Mercer also recommends this Division oversee state psychiatric hospital financing.

Division of Systems & Payment Monitoring

Mercer recommends that information technology (IT) services be combined into a single service entity. A move toward early integration of key IT functions that would benefit the HRSA Divisions should be applied. To build the foundation for a single IT service entity, Mercer recommends:

- integrating project management and governance;
- defining and managing systems security from an enterprise perspective; and
- implementing and maintaining HIPAA compliance (e.g., the National Provider Identifier – NPI regulations) centrally.

As the first priority, IT support for MHD must be addressed. MAA has already begun to explore using the current Medicaid Management Information Services (MMIS) to support MHD, and this effort must be accelerated to resolve issues around Regional Service Network (RSN) encounter data submission and reporting. This initiative should be treated as a formal project with defined resources, tasks, and deadlines. Technology support for the state hospitals should be evaluated separately, as suggested by interviewees, and the priority for this effort can be assigned once service integration is complete.

While MHD presents the immediate concern, there appear to be opportunities for increased data sharing; for centralizing expertise to support future DASA IT and business initiatives; and for common initiatives focused on planning and service delivery, care coordination, research, utilization management, reducing fraud and abuse, and client risk assessment and evaluation. To the extent possible, all Divisions should eventually share the same payment and decision support systems. The shared MMIS reprourement project offers the opportunity to make this vision a reality by integrating business requirements across all Divisions of the realigned HRSA organization. To the extent that this vision can be realized, HRSA should gain both operational and technology efficiencies as well as increase its ability to manage shared clients.

Managing Change

Finally, the realignment of the MAA Divisions and restructuring HRSA to include MAA, DASA, and MHD will require a cultural shift from independent “silos” to more interdependent operations. This shift will require strong leadership, time, and dedicated resources for the HR functions, including staff training and development and succession planning. Communications and supervisory strategies must promote the interdependence of staff working in multiple locations and facing building/space challenges.

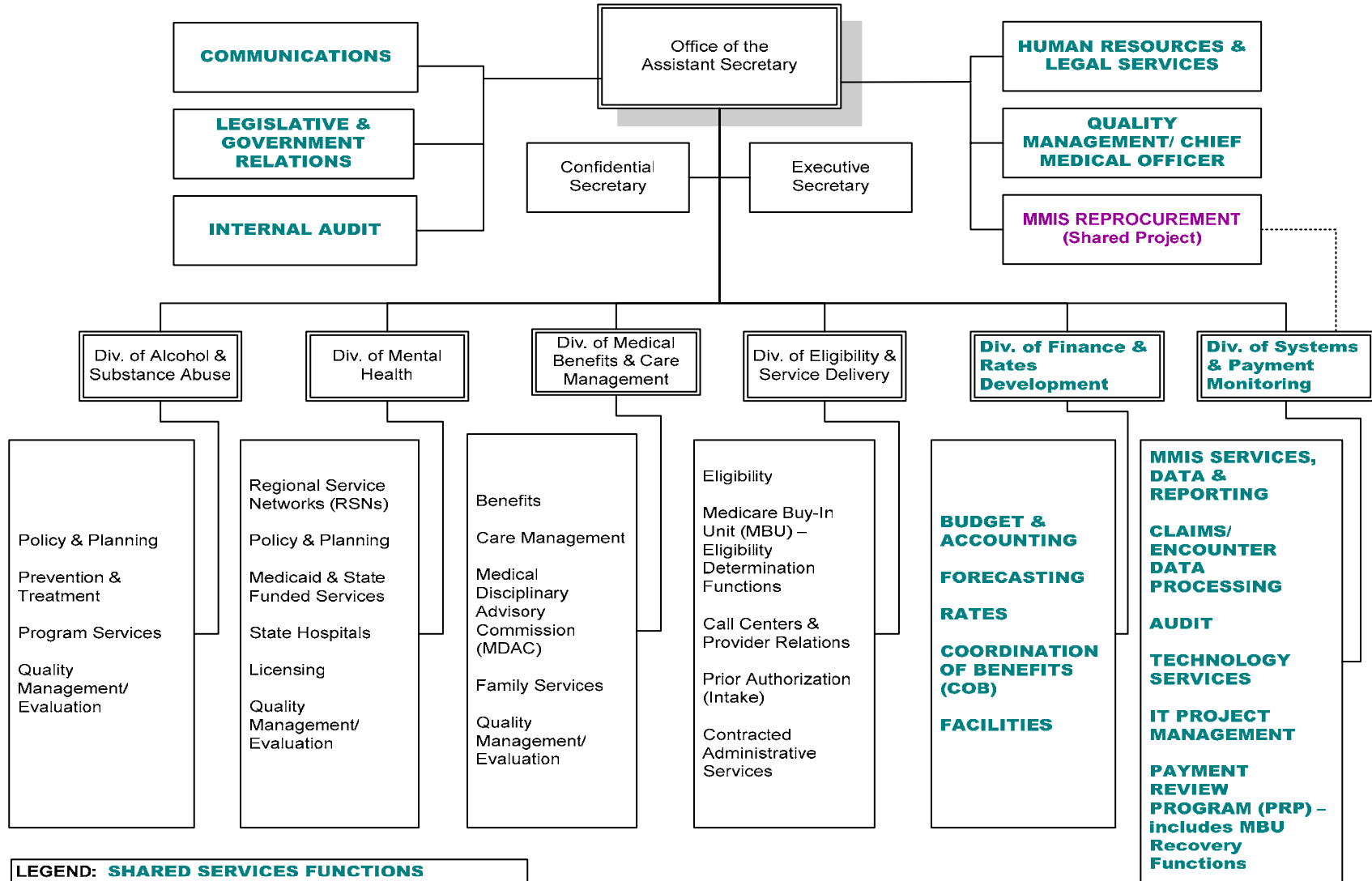
Mercer would like to extend our appreciation to the HRSA staff that provided us written information and participated in the interviews. The Mercer team appreciated the opportunity to assist HRSA with this review.

Highlights of Shared Services Recommendations

The following organizational chart highlights Mercer's key recommendations for shared services. Note that the chart depicts the following divisions and functions as shared services entities:

- Communications;
- Legislative & Government Relations;
- Internal Audit (new function);
- Human Resources & Legal Services;
- Quality Management/Chief Medical Officer;
- Division of Finance & Rates Development – including Budget & Accounting; Forecasting; Rates; Coordination of Benefits; and Facilities;
- Division of Systems & Payment Monitoring – including MMIS Services, Data & Reporting; Claims/Encounter Data Processing; Audit; Technology Services; IT Project Management; Payment Review Program (including Medicare Buy-in Unit {MBU} recovery); and
- The MMIS Reprourement Project, which is shown as a shared project; the dotted line indicates that once implemented, management of the replacement MMIS will be under the Division of Systems & Payment Monitoring.

RECOMMENDED HRSA ORGANIZATION AND SHARED SERVICES



The following table summarizes Mercer's recommendations by Division or function.

SUMMARY TABLE OF RECOMMENDATIONS

REALIGNMENT RECOMMENDATIONS BY DIVISION/FUNCTION

CONTRACTS MANAGEMENT AND MONITORING & OVERSIGHT OF CONTRACTORS

- Continue current approach for procuring major program contracts.
- Contracts Management, under the Office of the Assistant Secretary, should function as the central interface with DSHS, as well as be a gatekeeper for all contracts. Contracts Management should also manage all legal terms and conditions, ensuring consistency in all contracts procured within HRSA. Any contract gatekeeping positions in DASA should be consolidated under the HRSA Contracts Management function.
- Managing and monitoring program terms and conditions should be separate. Where positions actively monitor contracts on an ongoing basis, and their core competency is more related to acute health, mental health or substance abuse, or managed care, they should continue to reside within the appropriate division and continue to perform contact monitoring activities.
- Redefine some positions and titles to reflect that certain individuals are mainly responsible and accountable for monitoring and quality management. These positions can also assist managed care plans with day to day issues, but their primary role and focus should be monitoring and quality management.
- Monitoring of managed care plans should encompass medical management activities, network adequacy, and financial activities. Individuals within the Division of Benefits & Care Management should continue to monitor for medical management and network adequacy for physical health, focusing on a more robust, documented approach to monitoring each managed care plan and partnering with others, when necessary, for appropriate program or clinical expertise.
- Continue specialization in positions that monitor performance and quality for the medical management program and the purchased managed care programs.
- Distinguish between clinical quality management and monitoring of financial activities and administrative contract compliance.
- Establish a formal quality assessment and performance program administration-wide, with the participation of all divisions to assist with setting priorities and sharing technologies for quality management and monitoring.

REALIGNMENT RECOMMENDATIONS BY DIVISION/FUNCTION**AUDIT & MONITORING**

- Move the drug rebate program to the Division of Finance & Rates Development under the Budget & Accounting function.
 - Move the public disclosure function to HRSA Legal Services. Determine the extent to which program-specific expertise is needed to support the public disclosure function, and how to ensure that this expertise is available if the public disclosure function is moved to Legal Services and/or consolidated for MAA, MHD, and DASA.
 - Explore creating an Internal Audit function, which may include the authority to perform independent appraisals of all HRSA programs, contracts, divisions, and individuals receiving funds from HRSA.
 - Explore what type of monitoring MHD will perform for contracting RSNs, what skills and resources will be required to conduct such monitoring, and whether such monitoring could be included in a shared services function within HRSA.
 - Undertake a formal project to explore the audit and monitoring frontier and identify mutually beneficial opportunities to share resources and expertise. Tackle audits conducted at headquarters first, and then determine how and when to stage review of the MHD State Hospitals.
 - Once HRSA determines the extent to which shared services can occur, adequate staffing to support the model must be addressed, along with the extent to which additional staffing could be funded from recovery savings or be achieved through re-deployment of existing positions.
-

QUALITY MANAGEMENT/CHIEF MEDICAL OFFICER

- Include medical management of the FFS program in the Medical Benefits & Care Management Division.
 - Establish an administration-wide quality management (QM) program, which includes a formal plan and a QM committee with representatives of the Divisions, health plans, and PIHP/RSNs to assist the Administration with prioritizing quality improvement activities and finalizing a QM strategy.
 - Designate a formal QM Manager for the Administration, either reporting to the Medical Benefits & Care Management Division Director, or to the Chief Medical Officer.
 - Formal QM staff should be designated in the Benefits & Care Management Division, DASA and MHD.
 - QM activities should be performed by staff trained in the specialty areas of alcohol and substance abuse, mental health, and physical health; staff should reside in their respective Divisions. However, the QM program goal should be to share QM technologies and standards across Divisions, where appropriate.
 - The Chief Medical Officer should have a primary role in developing strategies and goals of the Administration's QM Plan, in consultation with psychiatrists and addiction specialists within HRSA's divisions and mental health/substance abuse experts knowledgeable about recovery.
 - The Deputy Assistant Secretary should participate on the QM Committee to help manage QM priorities and goals and provide direct access/information to the Assistant Secretary.
-

BUDGET & FINANCE, ACCOUNTING, FORECASTING, RATE SETTING & FFS RATE DEVELOPMENT

- Use a shared services approach for budgeting, finance, accounting, forecasting, rate setting and FFS rate development, for all divisions, including MHD and DASA.
- Create a shared service entity for financial activities as soon as possible for MHD, due to the number and complexity of financial issues facing the Division.
- A team of individuals from the Division of Business & Finance, MHD, and HRSA should closely examine all processes and functions in Budget, Finance, Accounting, Forecasting and Rate Development to explore in detail how a shared services organization would be organized. This can be accomplished after MHD fiscal staff and activities are merged with MAA, with the final organization put in place once opportunities for shared services are identified and reasonable work plans are developed to accomplish this.
- Research related functions may also lend themselves well to a shared services approach, particularly more analytical research.
- Facilities financial management also lends itself well to a shared service or centralized approach; this function should reside in the Division of Finance & Rates Development.
- The impact of the new MMIS should be examined. A robust financial module will be important to gaining maximum efficiencies in a shared services approach.

LEGAL SERVICES

- Distinguish between oversight and coordination of legal functions and divisional responsibilities to develop substantive work products and recommendations for Legal Services.
- Divisions will retain the responsibility to prepare materials to address provider disputes, make recommendations on rules and regulations, and manage the procurement and contracting process.
- Recommendations for establishing specific responsibilities of the divisions distinct from responsibilities of Legal Services are discussed in the relevant sections of this report.

COMMUNICATIONS

- Centralize communications for MAA, DASA and MHD under the Office of the Assistant Secretary for internal and external communications.
- Expansion of MAA's intranet for use by DASA and MHD will provide opportunities to improve internal communications.
- Central communications staff could set standards for media responses, press releases, and information on services and access; and coordinate with DSHS communications.
- State Hospital staff providing communications should be linked to the HRSA communications office, possibly through a "dotted" line supervisory chain. Because the state hospitals usually have a strong presence in their local communities as employers and providers, it is important to tailor their communications to both local and statewide issues.
- Consider changing the supervisory structure to direct oversight of the State Hospitals after assimilating responsibilities for DASA and other MHD functions.

HUMAN RESOURCES

- Centralize HR services in a single location, sufficiently staff the function, attain some degree of oversight of State Hospital HR staff that will continue to be located at the institutions, and organize for clearer lines of accountability to support deployment of consistent HR policies and practices. A shared services approach for HR offers many benefits and efficiencies, but cannot be effectively accomplished without addressing perceived staffing deficiencies, co-location, and organizational structure changes.
- HRSA should conduct a careful analysis of its changing HR requirements and use the results of that analysis as a basis for determining an appropriate ratio of HR staff to employees, and the ratio of training staff to employees.
- Centralized coordination and management of mandatory training would benefit HRSA, MHD and DASA in assessing needs and ensuring compliance.
- The Manager for Workforce Advancement should take responsibility for oversight of mandatory training at the state hospitals.
- A shared services approach should facilitate maximizing existing resources to manage the personnel reform initiative.
- HRSA should begin collecting HR metrics for all Divisions under a shared services model.
- A shared services model should also include the State Hospitals.
- Co-locate HR staff, although it is recommended that State Hospital HR staff continue to reside at the institutions.
- A shared services model for HR services will offer distinct benefits to MHD and DASA to ensure that management and supervisory training and succession planning is addressed.

LEGISLATIVE & GOVERNMENT RELATIONS

- Establish a single tracking system for legislative inquiries and bill analysis to prioritize needs and initiatives within HRSA, including development and publication of rules and regulations.
- Note that the Medical Benefits & Care Management Division, DASA and HRSA will still need to research and respond to program and regulatory issues, thus this organization will not necessarily result in staffing efficiencies.
- HRSA's legislative and government relations staff must assist the divisions with the focus and scope of direct communications with legislature and other government agencies.

COORDINATION OF BENEFITS

- The new MMIS presents opportunities for cross-divisional support and collaboration, such as helping RSNs and mental health centers identify Medicaid eligibles with other insurance. MAA can share expertise and information on Medicaid clients with MHD and the state hospitals.
- The State Hospitals should continue to handle Coordination Of Benefits (COB) internally, rather than attempt centralization within HRSA.
- Before the new MMIS is implemented, MAA should share information and expertise with MHD, and undertake joint discussions to determine whether collaborative opportunities around COB/TPL investigation exist.
- HRSA should split the financial recovery functions out of the MBU and place them in the Division of Systems & Payment Review, while retaining the more complex eligibility determination functions with the Division of Eligibility & Service Delivery.

INFORMATION TECHNOLOGY

- Mercer believes that IT management across the divisions must be collaborative and integrated, and that a move toward immediate integration of project management and resource prioritization, among other functions, would benefit the divisions.
- Integration should occur on a staged basis, with the ultimate goal of merging into a single service entity. The MMIS Reprourement Project represents one vehicle for moving toward greater integration and shared payment and decision support systems.
- Mercer recommends that the HRSA Assistant Secretary establish a policy direction and sponsor efforts to achieve a single, consolidated IT service delivery organization which would pave the way for the Divisions to work together to achieve this end.
- Given the realignment, Mercer recommends that HRSA reassess the recommendation to implement a new system for MHD if there are opportunities to leverage resources across divisions. Further, Mercer recommends that HRSA re-evaluate work in progress to replace the State Hospital Integrated Patient Information System (SHIPS).
- As the first priority, IT support for MHD (non institutional functions) must be addressed. MAA has already begun to explore using the current MMIS to support MHD, and this effort must be accelerated to resolve issues around RSN encounter data submission and reporting.
- DASA IT support should be the second priority. There appear to be opportunities for increased data sharing; for leveraging the expertise of MAA to support future IT and business initiatives; and for common initiatives focused on planning and service delivery, care coordination, research, utilization management, reducing fraud and abuse, and client risk assessment and evaluation.
- IT support for MHD institutional functions should be the third priority.
- Further, Mercer recommends moving toward early integration of certain IT functions, including integrating project management and governance; defining and managing systems security from an enterprise perspective; and implementing and maintaining HIPAA compliance (e.g., the NPI regulations) centrally.
- Finally, Mercer recommends that the HRSA Assistant Secretary assure that an adequate budget is secured to support the IT integration effort.

STATE HOSPITALS

- Continue having the state hospitals reside within the MHD.
- The nature of the operations of the State Hospitals is different, however, so Mercer recommends implementing shared services first for all other programs within HRSA, followed by shared services, where appropriate, for the State Hospitals.
- Mercer recommends that there be a direct line of accountability from the State Hospital CFO to the Director of the Division of Finance & Rates Development. This will ensure fiscal operations are appropriately managed within the context of the broader HRSA organization and simplify budgeting and other fiscal interactions with DSHS.
- Human Resources (HR) staff should remain within the institutions; however, HR staff should follow HRSA HR protocols and requirements and also have a direct line of accountability to HRSA HR to address HR standards and requirements.
- Each facility should have a Quality Management (QM) function and identify QM goals and priorities. MHD should include hospital QM goals in its portion of the HRSA QM plan and these should be reviewed by the HRSA QM Committee.
- Maintain Communications staff at the State Hospitals to address local issues resulting from the hospital's employment policies and patient care. Communications staff should have a direct line of accountability to the HRSA communications office.
- Legislative Affairs and Government Relations should be addressed through MHD and the HRSA communications office, with guidance from the facilities on local issues.
- For State Hospital Information Systems, similar to finance, Mercer recommends that shared services be implemented first for other programs within HRSA, but there should be a direct line of accountability to the HRSA Division of Systems & Payment Monitoring.

MHD OTHER SERVICES

- Several MHD administrative functions could be managed at the HRSA administration level.
- There are also a number of functions that do not fit in well with a shared services model at this time and should be retained by MHD.
- A table in the section on MHD Other Services identifies these functions.

2

INTRODUCTION

Mercer Government Human Services Consulting, the government specialty group within Mercer Human Resource Consulting (Mercer), was engaged to conduct an organizational and operational review of the newly established Health and Recovery Services Administration (HRSA). This new organization combines seven divisions from the former Medical Assistance Administration (MAA) with the divisions of Mental Health and Alcohol and Substance Abuse from the former Health and Rehabilitative Services Administration. The scope of this review included the following major tasks:

- review the proposed organizational alignment for MAA that was planned prior to the reorganization creating the Health and Recovery Services Administration;
- provide an independent assessment of the strength of the proposed organizational structure;
- build upon Mercer's initial analysis of the Mental Health Division (MHD) and the 2001 Mercer report on MAA by expanding the review to the new HRSA organization (See Mercer Reports: *May 2005 Operations Review, Washington State Department of Social and Health Services Mental Health Division*; and *August 2001 Medical Assistance Administration Organizational Review*);
- assess HRSA's ability to achieve administrative efficiencies while maintaining programmatic specialization in the critical areas of mental health, acute physical health and alcohol and substance abuse;
- identify functions not covered in Mercer's review of the managed Medicaid program at MHD;
- review the current monitoring approach for oversight of acute health care, placing special emphasis on provider relations and contract management; the goal of this task is to determine if there are complimentary and/or overlapping contract monitoring functions that can be consolidated and shared among the HRSA divisions; and
- identify non-Medicaid functions provided by the MHD.

Our approach, findings and recommendations follow.

3

APPROACH

Our proposed approach consists of the following three key phases:

- Phase 1: Preparation
- Phase 2: Review and Analysis
- Phase 3: Reporting

During Phase 1, Mercer completed an information request and received and reviewed various documents, which included, but were not limited to, the following:

- relevant organizational charts;
- description of Medicaid waivers and state plan services;
- current operational descriptions;
- high level budget documents;
- sample managed care contracts;
- relevant state and federal reports;
- CMS review notes;
- information systems descriptions;
- contract management materials; and
- key high-level policies applicable to areas of review.

Mercer also relied upon information obtained from the previous MHD review. All materials were reviewed during the preparation phase to ensure efficient interviews during Phase 2.

For Phase 2, Review and Analysis, with the assistance of the Office of the Assistant Secretary, interview schedules were developed. In order to focus the review, it was limited to interviews in the following key functional areas:

- Contracts;
- Audit Findings;

- Information Technology (IT);
- Communications;
- Managed Care Procurement;
- Legislative Services;
- Budget and Finance;
- Rate Setting;
- Accounting;
- Forecasting;
- Audit and Monitoring;
- Quality Management;
- MHD Other Services;
- Human Resources;
- Coordination of Benefits (COB); and
- Legal: Contracts and Client/Provider Disputes and Hearings.

Mercer conducted interviews with various individuals on all of the areas listed above between August 9 -12, 2005. A summary of the interview schedule is included in **Appendix 1**.

Interviews focused on understanding the environment in the past, present, and near future; and on high-level functions, policies, and established processes. In each interview, Mercer attempted to gain information relevant to the following goals of HRSA:

- organizational and functional alignment;
- administrative efficiencies;
- clear lines of accountability;
- accountability with checks and balances; and
- leveraged strength of resources across HRSA.

A preliminary exit interview was held August 11, 2005 with the Office of the Assistant Secretary based upon our initial analysis and findings gained from the various interviews and review of materials prior to the interview process.

The development of this report represents Phase 3 of our work.

4

FINDINGS AND RECOMMENDATIONS

MAA ORGANIZATIONAL REALIGNMENT PRIOR TO HRSA

OVERVIEW

The MAA organizational realignment refers to the organizational realignment prior to MHD and DASA becoming Divisions within HRSA. **Appendix 2** depicts the current MAA structure. **Appendix 3** depicts the proposed organizational realignment (including MHD and DASA).

Realignment Objectives

We understand the objectives of the organizational realignment to be as follows:

- foster greater collaboration or interdependence among Divisions;
- identify opportunities for improved operational efficiencies;
- elevate decision making to the appropriate levels;
- create clear lines of accountability;
- provide for appropriate checks and balances of functions; and
- leverage strength of resources across MAA.

Our understanding of the key changes resulting in the organizational realignment is depicted in the following diagram:

| Former Divisional Structure | | HRSA Divisional Realignment | |
|-------------------------------------|-----|--------------------------------------|--|
| ■ Disability Determination Services | ... | ■ No Change | |
| ■ Policy & Analysis | ⇒ | ■ Legislative & Government Relations | |
| ■ Business & Finance | ⇒ | ■ Finance & Rates Development | |
| ■ Customer Support | ⇒ | ■ Eligibility & Service Delivery | |
| ■ Audit & Information Systems | ⇒ | ■ Systems & Payment Monitoring | |
| ■ Quality Management | ⇒ | ■ Benefits & Care Management | |
| ■ Program Support | | | |

Other changes include the following:

- Managed care and FFS oversight and operational functions will work side by side.
- Legal Services will include Human Resources, Rules, Administrative Hearings, and certain Contracts functions.
- Legislative and Government Relations moves from the Division of Policy & Analysis to the Office of the Assistant Secretary as a support function.
- Claims Processing moves from the Division of Program Support to the Division of Systems & Payment Monitoring.
- Coordination of Benefits (COB), along with the Medicare Buy-in Unit (MBU) recovery functions, moves from the Division of Customer Support to the Division of Finance & Rates Development.

FINDINGS AND RECOMMENDATIONS

This report presents the professional opinions of Mercer, based on the review objectives outlined by HRSA, the materials provided for review, a limited number of interviews with key staff, and Mercer's many years of experience working with Medicaid and other government sector health care organizations. While the review conducted was not intended to be all encompassing, we believe it is thorough and presents solid recommendations for the HRSA realignment.

Overall, the organizational realignment is more supportive of the realignment objectives stated above than the current structure. Specific comments and recommendations are as follows:

- Fewer Divisions will help to create efficiencies, encourage greater interdependence, and better leverage resources by creating fewer perceived barriers or walls (Divisions).
- There is greater clarity under this realignment around each Division's main mission.
- Divisions represent several major policy areas:
 - *Benefits* policies are mainly addressed in the Division of Benefits & Care Management.
 - *Medicaid Eligibility* policies are mainly addressed in Division of Eligibility & Service Delivery.
 - *Rates* policies are mainly addressed in Division of Finance & Rates Development.
- Achieving appropriate interdependence among Divisions will be a challenge. During interviews, multiple examples were provided where decisions were made in one Division without consulting another Division that would be impacted.
- Established protocols around decision making and policy development are needed to reinforce an interdependent environment. The realignment itself is not enough to change the culture around interdependence.
- Changing the culture to place emphasis on interdependence will be important to the ultimate success of the realignment. This new structure is supportive of the desired culture.
- Physical separation of Divisions could make administration-wide cultural change more difficult. We understand the new building will mitigate some, but not all, of the challenges inherent with multiple locations.
- Guiding principles of the new organization should be developed and shared with all employees to shape a new organizational culture:
 - define what it means to work interdependently;
 - clarify the roles of functional responsibilities versus population specific responsibilities and cross-divisional responsibilities;
 - clarify the mission and vision of each Division;
 - clarify the mission and vision of the new organization; and
 - define what it means for the administration to be successful through the support of its Divisions – not necessarily what it means for a Division to be successful.
- While an advantage of a more interdependent environment is improved decisions based upon more meaningful input, one disadvantage can be slower decision making. Again, protocols and guiding principles will be needed to avoid inappropriately slowing down

processes and decision making. And better decisions should result, creating greater efficiencies in the longer term.

- It will be necessary to assess whether each Division and Section leader is supportive of a more interdependent culture. All leadership must be supportive of this new direction or be redirected elsewhere. Otherwise, the objectives above will likely not be achieved. Leaders in a more interdependent culture tend to lead by influence rather than authority, seeking others' input (and being sought by others) on decision-making.
- Several interviewees suggested maintaining policy development separate from operations. Fewer Divisions make it more difficult to achieve true separation, but assigning different Section managers over policy as distinct from operations should mitigate this. Division leaders will be charged with resolving conflicts between policy compliance and the availability of resources to comply.
- The supporting functions of Communications, Legislative & Government Relations, Human Resources, and Legal Services cross over all Divisions and will need to assume a customer service role, supporting the Office of the Assistant Secretary and Divisions as appropriate.
- Communications with employees around this realignment will be important. Designating a point person for the realignment and posting Q&As on an intranet are examples of approaches that might be helpful during the organizational change.
- The need for improved monitoring and oversight of various business functions and vendors was a central theme in most interviews. This is also supported by preliminary CMS audit findings. The responsibility of monitoring and oversight isn't clear in the new organizational realignment in terms of where it resides, who does it, and what is required to be done (other than the audit function in the Division of Systems & Payment Monitoring). Mercer will provide recommendations on options for monitoring during our discussion of key functional areas.
- The absence of a designated quality management program in the organizational structure is a gap. A discussion of quality management functions is included in the review of medical management and the medical director role later in this report.
- Organizational structures are most supportive when all departments or divisions share a common mission and vision, and support the same core competencies. The Division of Disability Determination Services does not appear to fit well in the new HRSA. Consideration should be given to moving this to an agency separate from HRSA.
- The new MMIS is a big undertaking for HRSA and critical to its ultimate success. Given the introduction of MHD and DASA into the organization, it makes sense to ensure that the capabilities of the MMIS are supportive of all division's future directions, to the extent feasible. Because the new MMIS will also impact ongoing operations affecting the current MMIS Services and Claims and Encounter Processing, the current structure of accountability to the Office of the Assistant Secretary, as well as to the Division Director for Systems & Payment Monitoring, should be continued.

HRSA ORGANIZATIONAL STRUCTURE WITH MHD AND DASA

OVERVIEW

The HRSA organizational structure is depicted in **Appendix 2** with the only change from the previous section being the addition of MHD and DASA to the new organization now called HRSA.

FINDINGS AND RECOMMENDATIONS

Mercer concurs with the proposed organization in that MHD and DASA should be separate divisions within HRSA, maintaining separate identity and visibility.

- A separate identity enables a structure that can continue to support the unique needs of DASA and MHD.
- Stakeholders will continue to have points of contact within these Divisions that understand and can address their unique issues.
- Staff with appropriate specialized skills and experience can more likely be retained and developed, and new talent recruited, including a new Director for MHD.

To provide for increased efficiencies, certain operational aspects of DASA and MHD should be examined in the context of shared services supported by other Divisions within HRSA. Mercer will provide recommendations on options for shared services during our discussion of key functional areas.

The term shared services means what it implies. Certain Divisions, such as Finance and IT, are responsible for providing services that are used by *all* Divisions. All Divisions, including DASA and MHD, share certain services, retaining appropriate control over various aspects of that shared service.

Mercer also recommends modifying the name of the Division of Benefits & Care Management to the Division of *Medical* Benefits & Care Management to provide a clear focus for physical health care policy and operations and to distinguish between the Mental Health and Alcohol and Substance Abuse Divisions.

During interviews, some concern was expressed regarding how services are prioritized in a shared services model. For example, who determines which IT project gets priority? Mercer recommends that a prioritization process be developed, with the Office of the Assistant Secretary having final authority over prioritization.

CONTRACTS MANAGEMENT

OVERVIEW

The contracts management function could consist of several roles, depending upon how contracts management is defined:

- procuring the contract, including development of the contracts;
- interfacing with DSHS and functioning as the gatekeeper for all administration contracts;
- managing and monitoring legal terms and conditions for all contracts; and
- managing and monitoring program terms and conditions for all contracts.

Under the organizational realignment, there is a contracts management role residing in the Office of the Assistant Secretary. The contracts management role within the Office of the Assistant Secretary appears to focus primarily on legal terms and conditions and interfacing with DSHS Central Contracts Office. Remaining contracts management functions (i.e., procurement and managing/monitoring program contractual terms and conditions) occur within the various Divisions.

FINDINGS AND RECOMMENDATIONS

Procuring Contracts

Our discussion around procuring contracts focused on major program contracts, such as procuring RSN services, acute care managed care contracts, or major care initiatives. Our review did not address routine types of contract procurement for items such as supplies or equipment.

Major program contracts occur relatively infrequently (every few years). For these types of procurements, we recommend continuing the current approach. Our understanding of the current approach is that someone within the program area assumes a lead role for the procurement, partnering with Contracts Management and other experts throughout the administration, such as finance and technology, to develop a best-in-class team to procure the contract. Cross-divisional teams will help to ensure all interests are represented in the contract. This approach would also work well for MHD and DASA with each taking the lead on their respective procurements, but partnering with other Divisions for expertise, input, etc. Whoever assumes the lead role should have some experience in large program procurements.

Interfacing With DSHS and Gatekeeper Role/Managing Legal Terms and Conditions

The Contracts Management role residing in the Office of the Assistant Secretary should function as the central interface with DSHS, as well as assume a general gatekeeper role for all contracts. This role or office would also be the source for managing all legal terms and conditions, and ensuring consistency in all contracts procured within HRSA. This group can also ensure that a single log or directory of all outstanding contracts, expiration dates, etc. are maintained and monitored to ensure that action around re-procuring is taken on a timely basis.

These positions would generally be contracts specialists who know a little about most programs.

We understand that there may be some contract specialist positions devoted to gate keeping in DASA. If these positions are truly gate keeping and not actively managing ongoing contracts from a monitoring or oversight perspective, it may make sense to move these positions to the Contracts Management office within the Office of the Assistant Secretary. Over time, workflow within the Contracts Management unit should be evaluated to determine if all positions are needed or if one or two positions can be eliminated or redeployed to other areas.

Managing and Monitoring Program Terms and Conditions

Managing and monitoring program terms and conditions is somewhat complex and is likely more effective when done by individuals with expertise in a particular area, such as mental health, acute health, etc. We concur that these responsibilities should be separate from the responsibilities assumed by the Contracts Management function within the Office of the Assistant Secretary.

While it could be an option to move all contract monitoring specialists together in one Division, including those from DASA and MHD, at this point we recommend that where positions actively monitor contracts on an ongoing basis, and their core competency is more related to acute health, mental health or substance abuse, or managed care, they continue to reside within the appropriate division and continue to perform contract monitoring activities. Again, as appropriate, they would partner with other Divisions or the Contracts Management office. Over time, this should be re-evaluated to see if further efficiencies could be gained by centralizing some contract monitoring activities.

See also the discussion below on monitoring and oversight that follows.

MONITORING AND OVERSIGHT OF CONTRACTORS

OVERVIEW

Monitoring and oversight of contractors in the context of this report refers to monitoring of the major program contracts, which include, but may not be limited to, the following:

- Managed care organizations for the acute health programs;
- Other care management contracts for the acute health programs;
- RSNs contracting with MHD; and
- Providers/entities contracting with DASA.

FINDINGS AND RECOMMENDATIONS

The new organizational structure isn't clear as to where monitoring responsibilities reside. Further, there is no specific mention of quality management. In part, this is because monitoring and quality management occur in multiple divisions, so this lack of clarity may represent the intent to have continuous quality management integrated into daily operations.

As a result of the Balanced Budget Act, Federal regulations (CFR Title 42: D§ 438.202) require states to implement quality assessment and performance improvement strategies to ensure the delivery of quality health care by all managed care organizations (MCOs), pre-paid inpatient health plans (PIHPs), and pre-paid ambulatory health plans (PAHPs). CMS and external stakeholders are placing increased emphasis on monitoring and oversight of programs and vendors. Both want to ensure value for their purchasing dollars. Clearly defining monitoring and oversight roles in HRSA, including a formal quality management program that creates accountability around monitoring roles, will be critical to ensuring these activities are performed satisfactorily.

Given the significance that CMS places on monitoring and quality management, it may make sense to redefine some positions and titles to reflect that certain individuals are mainly responsible and accountable for monitoring and quality management. These positions can also assist managed care plans with day to day issues, but their primary role and focus should be monitoring and quality management.

Monitoring Managed Care Contracts

Mercer had access to preliminary notes from a CMS review completed about one year ago. Consistent with what appears to be CMS' position for most state Medicaid programs, CMS believes that monitoring activities are not necessarily sufficient. No final report has been issued by CMS however, so their exact findings are not yet known.

Interviewees responsible for monitoring of managed care contracts within MAA indicate that they believe reasonable monitoring is being performed but acknowledged that a lack of resources has limited their ability to document such efforts.

Based upon what we have observed in other states, monitoring of managed care plans should encompass medical management activities, network adequacy, and financial activities. Under the organizational realignment, it would appear to make sense for individuals within the Division of Benefits & Care Management to continue to monitor for medical management and network adequacy for physical health, focusing on a more robust, documented approach to monitoring each managed care plan and partnering with others, when necessary, for appropriate program or clinical expertise. We recommend consideration of redefining certain positions to emphasize monitoring and quality management.

Mercer recommends continued specialization in positions that monitor performance and quality for the medical management program and the purchased managed care programs. We also recommend distinguishing between quality management and monitoring of financial activities and administrative contract compliance. We will have a full discussion of quality assessment and performance monitoring activities under the Medical Management and Role of the Chief Medical Officer section.

For monitoring of financial activities, individuals within the Division of Finance & Rates Development may be most appropriate for monitoring managed care financial activities. This can be accomplished primarily through rate development activities, focusing on the adequacy of the rates being paid for services so that the rates are not excessive or inadequate. (See also our discussion on Rate Setting and FFS Rate Development.)

Monitoring DASA and MHD Contractors

Monitoring, quality management and performance improvement are most effective when staff has expertise in a particular area and/or program. Therefore, Mercer recommends continuation of these monitoring functions within MHD and DASA for now, with the possibility of reassessing this at a later date. However, a formal quality assessment and performance program needs to be established administration-wide with the participation of DASA and MHD to assist with setting priorities and sharing technologies for quality management and monitoring. The components of a formal quality management program will be discussed later in this report.

AUDIT AND MONITORING

OVERVIEW

HRSA requested Mercer's review of the audit and monitoring functions currently residing within the Division of Audit and Information Systems (DAIS), which under the realignment will reside in the Division of Systems & Payment Monitoring. Functions reviewed included discussion of desk and onsite audits, data mining and analysis, reporting and compliance monitoring. Monitoring in this context refers to monitoring for payment accuracy

DASA and MHD audits and monitors its contracts through a combination of fiscal, IS, and program staff functions. We recommend assessing each of these functions within DASA and MHD and moving to a shared services model for financial auditing and monitoring.

Our review of HRSA's Audit and Monitoring function indicates that there are solid opportunities for adopting a shared services model, using a single source of data to maximize post payment recovery and support other audit and monitoring functions. Our findings and recommendations are detailed below.

FINDINGS AND RECOMMENDATIONS

In terms of organizational and functional alignment, the proposed realignment now places Claims Processing together with the DAIS audit and monitoring functions, and retains the current structure of housing audit and monitoring with other IT functions that currently coexist within DAIS. (Once the new MMIS is implemented, HRSA's intent is to maximize electronic claims submission and processing, thus moving the claims processing function closer to the IT functions. This is the rationale for placing Claims in the Division of Systems & Payment Monitoring.) Overall, this appears to be a logical organization; the auditing work feeds directly back into automated system audit/edit development. However, interviewees identified certain functions that may more logically fit elsewhere:

- **The drug rebate program** is currently an Office of Payment Review (OPRA) responsibility, and entails invoicing manufacturers for rebates and resolving claim disputes. Under the proposed realignment, this function will be moved to the Division of Finance & Rates development under the Budget & Accounting function which Mercer agrees makes more sense, since the primary responsibility is invoicing and collection of rebates rather than audit.
- **Public disclosure** is a current responsibility of the Office of Medicaid Services & Data (OMSD), which serves as the lead point of contact for HRSA within DSHS. (MHD and DASA also have their own Public Disclosure Coordinators.) DAIS staff indicated that this function more logically belongs with other legal services and Mercer concurs, although we recommend that HRSA determine the extent to which program-specific expertise will be needed to support the public disclosure function, and how to ensure that this expertise is available if the public disclosure function is moved to Legal Services and/or consolidated for MAA, MHD, and DASA. We acknowledge that MHD and

DASA must comply with a myriad of strict Federal regulations for disclosure which may exceed the standard HIPAA privacy requirements that apply in non-mental health and substance abuse situations.

The OPRA hospital retrospective review function was raised as an issue as well. OPRA has three RNs and one Registered Health Information Technician (RHIT) who conduct retrospective hospital utilization review, enforcement of Department policy for hospital UR, review for medical necessity, etc. Staff suggested that this may more logically fit under the Division of Medical Management (which under the realignment will be organized with the Division of Benefits & Care Management). Mercer considered this suggestion; however, maintaining the function as is allows HRSA to keep all retrospective review together. Further, from an information sharing perspective, there is an advantage to having the clinical staff that performs retrospective review located together with financial staff that performs onsite hospital audits.

Internal Audit

An Internal Audit function does not currently exist within HRSA, although staff indicated that HRSA spends considerable time reviewing data for the State Auditor. Mercer recommends that HRSA explore the need to create an Internal Audit function, which may include the authority to perform independent appraisals of all HRSA programs, contracts, divisions, and individuals receiving funds from HRSA. Internal Audit appraisals may include financial and performance audits, risk analysis, and investigations of alleged misconduct and illegal activities. However, to retain clear lines of accountability and appropriate separation of duties, Mercer recommends that, if an Internal Audit Division is created, it should report directly to the Assistant Secretary rather than through the Division of Systems & Payment Monitoring. Reporting directly to an organization's executive branch is typical for Internal Audit functions due to the potential scope and sensitivity of Internal Audit's responsibilities.

Monitoring MHD RSNs

The Payment Review Program (PRP) focuses on electronic monitoring of data and development of information and models to target high-probability cases for payment accuracy review. Reviews are primarily provider-focused at present; however, PRP does not perform review of acute care medical managed care contracts. PRP has in the past performed data matches between the FFS Medicaid data and the RSN encounter data resulting in changes to current policy. OPRA also conducts audits of providers such as Federally Qualified Health Centers (FQHCs).

This raises the question of whether and how the new Division of Systems & Payment Monitoring could assume responsibility or provide assistance for monitoring the MHD RSNs. Mercer recommends that further exploration occur to determine what type of monitoring MHD will require of contracting RSNs, what skills and resources will be required to conduct such monitoring, and whether such monitoring could be included in a shared services function within HRSA. Key elements of MHD's audit and monitoring functions are described below. (See also our discussion of monitoring MHD and DASA contractors.)

- MHD, as a provider, monitors payment accuracy through its compliance program. Hospital audits are conducted regularly, and consist of comparing medical records against coded bills and relevant Medicaid regulations. Additional focused audits may be done at the direction of the MHD compliance officer, the Office of Inspector General (OIG) annual work plan, or as needed. Monthly reports are generated identifying codes and provider billing activity; and reports are monitored for any billing audit flags. Edits have been implemented to ensure that claims have complete and accurate information before being sent out, and denial trend tracking occurs. Many of these functions appear to be very similar to those currently performed by HRSA/PRP (e.g., the electronic monitoring approach of HRSA/PRP), and it appears there is good opportunity for a shared services approach as long as MHD programmatic expertise is retained. Further, a shared services approach to auditing would support the administration's desire to emphasize checks and balances throughout the divisions.
- Recovery of overpayments identified through the auditing process is coordinated with the Office of Financial Recovery (OFR). OFR repays funds to CMS, or CMS/Noridian withholds amounts from the next payment due. Monthly payments to the RSNs are adjusted in subsequent payments to account for overpayments or underutilization estimates; this process is performed by the MHD internal monitoring function. There appears to be some potential for a shared services model with the Division of Finance & Rates Development, which Mercer recommends be explored.
- MHD, as a purchaser, does not monitor payment accuracy. MHD's External Quality Review Organization (EQRO) (APS healthcare systems), performs encounter data validation. RSN contracts traditionally place the burden of ensuring accurate provider payments on the RSNs. If future RSN contracts continue to require the RSNs to monitor provider payments, MHD should explore opportunities to leverage expertise in HRSA's Division of Systems & Payment Monitoring to assist in the area of RSN contract oversight.
- Within MHD, the state hospitals audit all billing practitioners annually. Each of the major services provided at the hospital are audited, including psychotherapy, evaluation and management, ophthalmology, psychiatric assessment, physical therapy, etc. Western State Hospital audits 100% of all claims on a prospective basis and corrects problems before a bill is submitted. Eastern State Hospital conducts concurrent audits on a sample of services, provides audit results to practitioners, and reviews audit results with each of the hospital's compliance committees. Both state hospitals may benefit by leveraging the electronic monitoring approach of HRSA/OPRA, and opportunities should be evaluated for the conduct of prospective hospital claims auditing. This effort should be undertaken in conjunction with expertise from the Division of Systems & Payment Monitoring, particularly if this division assumes responsibility for hospital retrospective auditing as suggested earlier.
- In its Medicaid role, MHD monitors RSNs and other providers via the QA & I team, via the EQRO. However, it is important for MHD/HRSA to have an oversight function. RSNs are also contractually obligated to perform their own internal audits. As noted

above, MHD should explore opportunities to leverage expertise in HRSA's Division of Systems & Payment Monitoring to assist in the area of RSN contract oversight to ensure that RSN internal audits are being conducted.

Somewhat like a shared services model, PRP already provides services department-wide, using MMIS and Social Service Payment System (SPSS) data, common analytical algorithms, and managing the data warehouse and decision support system for data mining and data analysis across the 500 users it serves. In addition, data is also being supplied to MHD to support its rate calculations.

Identification of Opportunities for Shared Services

PRP's predominant users are HRSA and some DASA staff, although there have been recent discussions with MHD to familiarize its staff with PRP services. HRSA staff do not currently have a full understanding of either MHD's or DASA's audit requirements or processes, nor does it appear that MHD and DASA staff are fully informed regarding the audit processes at HRSA. Contacts between the HRSA, MHD, and DASA have been initiated, and Mercer recommends that a formal project be undertaken to explore the audit and monitoring frontier and identify mutually beneficial opportunities to share resources and expertise. We recommend that HRSA tackle audits conducted at headquarters first, and then determine how and when to stage review of the MHD State Hospitals.

OPRA's functions have a natural linkage with the Office of Medicaid Services & Data (OMSD) in terms of data accessibility and usage issues. DAIS has less linkage to contract monitoring at this time; and staff are uncertain whether monitoring MHD RSNs would be outside the scope of their work as well. The issue of RSN monitoring should be explored as part of the formal project recommended above. It appears feasible for OPRA to expand its services to MHD and DASA, now that these divisions are part of the HRSA organization.

OPRA also includes two units devoted to provider extrapolation audits, including performing medical record audits of providers, hospitals, and federally qualified health centers (FQHCs). A third unit is responsible for the MMIS State Utilization Review Subsystem (SURS) and provides intake for audit referrals; over 500 audit leads were received in FY05; 300 of these resulted in referrals, desk audits, or closure. The realignment of HRSA with MHD and DASA presents significant opportunity to maximize monitoring by leveraging the leads available through SURS and the expertise already present in HRSA across all Divisions.

Staffing for a shared services unit presents a concern. At present, OPRA has one vacancy in medical audit, one vacancy in hospital audit, and one additional vacancy that will occur at the end of August due to a retirement. OPRA has been allocated two additional FTEs on the presumption that specific target recovery levels will be achieved and that recovery savings will pay for the cost of the FTEs. Once HRSA determines the extent to which shared services can occur, adequate staffing to support the model must be addressed, along with the extent to which additional staffing could be funded from recovery savings or be achieved through re-deployment of existing positions.

Training for staff is also a concern. DAIS staff indicated that more technology training may be required for OPRA staff and for staff conducting hospital audits.

See also the discussion above on Contracts Management, Managing and Monitoring Program Terms and Conditions.

QUALITY MANAGEMENT / CHIEF MEDICAL OFFICER ROLE

OVERVIEW

Mercer reviewed the transition of Medical Management (FFS program) to the Benefits & Care Management Division and the future role of the medical director. In the existing organization, the Chief Medical Officer oversees medical management and has initiated quality management activities. In the proposed organization, medical management will transfer to the Benefits & Care Management Division. As mentioned previously in this report, there is no formal quality management program, although the Chief Medical Officer oversees several important performance improvement projects.

FINDINGS AND RECOMMENDATIONS

Mercer agrees with the proposed inclusion of medical management of the FFS program into the Benefits & Care Management Division and believes this change provides an opportunity to focus on quality improvement initiatives. While there will need to be distinct staff performing the medical management and the managed care procurement functions, there is the opportunity to share knowledge about evidence-based practices and quality initiatives between the programs.

The absence of an administration-wide quality management (QM) program is a significant gap that, if addressed, will assist the divisions to obtain better value for the dollars spent and to continuously improve the quality of care. A formalized quality management program will also address CMS requirements for quality assessment and performance improvement, and may mitigate some of the yet to be released findings from CMS' review. The administration-wide QM program would work with the Divisions to identify performance improvement opportunities. For example, the External Quality Reviews (EQR) of acute physical health and mental health typically identify strengths and gaps in the management of health and mental health care. The QM program could target recommendations from the External Quality Review reports to identify performance goals and strategies to facilitate improvements. Further, the availability of "clean" data to support the QM program is essential. The administration-wide QM program would work with the program Divisions (DASA, Acute physical health, MHD); the shared support Divisions (Finance and Rates, Systems and Monitoring); and the Office of the Assistant Secretary to identify key data elements necessary to analyze performance and outcomes. The opportunities to improve integration and coordination of physical health, alcohol and substance abuse, and mental health care are significant under the realignment. Mercer recommends establishing specific QM goals related to improved integration and quality of care as part of the QM program.

The components of a QM program include:

- A written QM Plan/written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs and the internal medical management

program. The plan must have the following high level components as specified by regulation (Refer to CFR, Title 42: D§438.204 Elements of State Quality Strategies for all specific requirements):

- mechanism for ensuring that MCOs and PIHPs comply with standards established by the State, consistent with CMS requirements;
- plan to assess the quality and appropriateness of care furnished to all Medicaid enrollees and to individuals with special health care needs; and
- strategies to regularly monitor and evaluate MCO and PIHP compliance with standards.

The plan must have the input of recipients and other stakeholders and also be made available to the public for comment before its final adoption.

- A quality management committee that comprises representatives of the Divisions, health plans, PIHP/RSNs. The committee will assist the Administration with prioritizing quality improvement activities and finalizing a QM strategy.

Mercer also recommends designating a formal Quality Management Manager for the Administration, either reporting to the Benefits & Care Management Division Director, or to the Chief Medical Officer. The quality management program could reside in, and be managed by, the Benefits & Care Management Division or the Office of the Deputy Assistant Secretary.

Formal QM staff should be designated in the Benefits & Care Management Division, DASA and MHD. QM activities should be performed by staff trained in the specialty areas of alcohol and substance abuse, mental health, and physical health. These staff should reside in their respective Divisions. However, it should be a goal of the QM program to share QM technologies and standards across Divisions, where appropriate. This can be done through active participation of the Divisions on the QM Committee. In Mercer's previous report on MHD, we recommended having two FTE QM staff per PIHP/RSN; this number could be decreased if clear and specific QM goals and reporting mechanisms are developed and monitored by the Administration-wide QM program. However, the RSNs have had limited quality improvement monitoring and will require substantial focus to administer the requirements specified in the RFQ to be released on October 1, 2005.

The Chief Medical Officer should have a primary role in developing strategies and goals of the Administration's QM Plan, in consultation with psychiatrists and addiction specialists within HRSA's divisions and mental health/substance abuse experts knowledgeable about recovery. It is also very helpful to have the input of recipients.

We also recommend the participation of the Deputy Assistant Secretary on the QM Committee to help manage QM priorities and goals and provide direct access/information to the Assistant Secretary.

BUDGET AND FINANCE, ACCOUNTING, FORECASTING, RATE SETTING AND FFS RATE DEVELOPMENT

OVERVIEW

Budgeting, finance, accounting, forecasting, rate setting and FFS rate development have been grouped together in our report based upon similarities in organizational structure and consistency of our findings. Under the proposed realignment, all of these functions reside within the Division of Finance & Rates Development. MHD and DASA currently have some or all of these functions within their Divisions as well.

FINDINGS AND RECOMMENDATIONS

Clearly, efficiencies can be gained by utilizing a shared services approach for budgeting, finance, accounting, forecasting, rate setting and FFS rate development, for all divisions, including MHD and DASA.

A fiscal or budget representative could remain in MHD and DASA and function as a liaison to the Division of Finance & Rates Development, offering MHD and DASA a central point of contact and someone who understands issues unique to each of their divisions.

Other than possibly a fiscal or budget representative remaining in MHD and DASA, it is recommended that all other services and functions (budgeting, finance, accounting, rate setting, FFS rate development) be supported through a shared services model and centralized in the Division of Finance & Rates Development. A discussion around some of the specific functions follows:

- Although program aspects differ, the budgeting process is very similar for all programs.
- Finance and accounting functions, particularly for functions such as routine accounts payables, require little to no program specialization.
- Efforts expended for forecasting are somewhat different for DASA, MHD and acute care, but MHD for example may benefit from more rigorous forecasting.
- Some specialization should continue to be maintained but could all reside within the Division of Finance & Rates Development. For example, DASA has a process whereby they redistribute funds to providers to ensure all funds available are used. This process likely benefit from specialized knowledge, but once again, could reside within the Division of Finance & Rates Development.
- The same actuaries as used for acute care rates are already used to develop rates for mental health.
- MHD and DASA already use certain parts of the Medicaid fee schedule developed for the acute care programs.

- The dollars at stake as a result of rate setting and rate development are enormous. Centralizing within one area managed by individuals with extensive related experience will be important to ensure rates are neither excessive nor inadequate.
- Responsibility for rate setting makes sense to be in the Division of Finance & Rates Development, but collaboration with managed care specialists in the Division of Benefits & Care Management and with other program specialists is needed.

Centralizing or using a shared services approach should result in increased efficiencies, allowing for elimination of some positions and/or creating opportunities for existing staff to be redeployed to areas of greater need. Creation of a shared service entity for financial activities should be accomplished as soon as possible for MHD due to the number and complexity of financial issues facing the Division. Mercer recommends that a team of individuals from the Division of Business & Finance, MHD, and HRSA closely examine all processes and functions in Budget, Finance, Accounting, Forecasting and Rate Development to explore in detail how a shared services organization would be organized. This activity can be accomplished after MHD fiscal staff and activities are merged with MAA, with the final organization put in place once opportunities for shared services are identified and reasonable work plans are developed to accomplish this.

Although a shared services model makes sense, MHD and DASA are currently on different accounting systems and have had virtually no cross training with HRSA, or vice versa. Converting to a shared services approach for accounting will be a large undertaking, requiring time and resources to implement initially, with savings achievable once the shared services model is implemented. This may also be a difficult process for some if they feel their positions are threatened by a shared services model.

Mercer noted during our interviews that research related functions (although not key functions that were part of our review) appear to be handled differently in MHD, DASA, and throughout HRSA. Research may also lend itself well to a shared services approach, particularly more analytical research.

Facilities financial management also lends itself well to a shared service or centralized approach. Residing in the Division of Finance & Rates Development appears appropriate.

Lastly, the impact of the new MMIS needs to be examined. A robust financial module will be important to gaining maximum efficiencies in a shared services approach.

LEGAL SERVICES

OVERVIEW

The proposed HRSA organization places legal services under the Office of the Assistant Secretary. This would include legal functions related to Human Resources, Administrative Hearings, Rules and Regulations, and certain contract functions related to terms and conditions, as well as other legal matters that come to the attention of HSRA.

FINDINGS AND RECOMMENDATIONS

The proposed organization provides a shared services model that could enhance oversight of legal issues and assist with establishing priorities and resource management. However, it will be important to distinguish between oversight and coordination of legal functions and divisional responsibilities to develop substantive work products and recommendations for Legal Services. For example, the divisions will still have the responsibility to prepare materials to address provider disputes, make recommendations on rules and regulations, and manage the procurement and contracting process. Related to contracts, HRSA's Legal Services office will focus on contract terms and conditions and act as the internal clearing house for the Assistant Secretary and Deputy Assistant Secretary. The DSHS Central Contract Services is the only entity within DSHS with the delegated authority to conduct procurements. So, all divisions must coordinate procurement activities through Central Contracts Services.

Recommendations for establishing specific responsibilities of the divisions as distinct from responsibilities of Legal Services are discussed in the relevant sections of this report:

- The recommendation for a separate Human Resources function under the Office of the Assistant Secretary is addressed in the Human Resources section of this report.
- A delineation of the division's contract responsibilities is discussed in the Contracts Management Section.
- Divisional responsibilities for rules and regulations are discussed in the Legislative and Governmental Relations section.

COMMUNICATIONS

OVERVIEW

The proposed HRSA realignment would centralize communications for MAA, DASA and MHD under the Office of the Assistant Secretary for internal and external communications. MAA has communications staff that would assume this role for HRSA. DASA and MHD staff providing communications support have a myriad of other duties. The state psychiatric hospitals have communications staff that addresses facility specific information needs and media contacts. These staff currently report to the facility administrators.

FINDINGS AND RECOMMENDATIONS

A shared services model for communications, with HRSA taking the lead, should be an efficient use of resources. Of particular benefit, staff interviewed suggested the expansion of MAA's intranet for use by DASA and MHD will provide opportunities to improve internal communications. The use of the intranet can assist HRSA with supporting the cultural change necessary to add DASA and MHD staff and promote better integration.

There are also advantages for external communications. While staff within the divisions will need to continue researching issues related to media requests and other public information, the central communications staff could set standards for media responses, press releases, and information on services and access; and coordinate with DSHS communications. These efforts could streamline the communications process. Because communications staff at DASA and MHD have other responsibilities, efficiencies from this change will most likely occur at the division level.

The state hospital staff providing communications should be linked to the HRSA communications office, possibly through a "dotted" line supervisory chain. Because the state hospitals usually have a strong presence in their local communities as employers and providers, it is important to tailor their communications to both local and statewide issues. Thus, these staff benefit from having local supervision as well as linkage to the HRSA communications. HRSA may want to consider changing the supervisory structure to direct oversight of the state hospitals after assimilating responsibilities for DASA and other MHD functions.

HUMAN RESOURCES

OVERVIEW

Under the proposed realignment, Human Resources (HR) support would be organized within the Legal Services function, reporting to the Deputy Assistant Secretary. HR faces numerous challenges as a result of the realignment and other factors, including Personnel Service Reform; existing gaps in consistent HR practices across HRSA, DASA and MHD; federal and state compliance issues; and scarce resources, among others. Interviewees see distinct advantages in terms of combining and coordinating HR expertise and resources, as discussed in our findings and recommendations below.

FINDINGS AND RECOMMENDATIONS

Overall, Mercer believes that a shared services approach for HR offers many benefits and efficiencies, but cannot be effectively accomplished without addressing perceived staffing deficiencies, co-location, and organizational structure changes. Mercer identified the following HR related issues that surfaced during our interviews:

HR Staffing

Mercer recommends sharing HR services across MAA, MHD and DASA. However, staffing is currently a key concern that impacts the quantity, quality and timeliness of HR services. Specific issues are outlined below:

- At present, there are five HRSA HR FTEs: one senior manager (HRM) and four HR consultants (HRC1s). The current HR organization chart shows the HRC1s reporting through dotted line matrix relationships to both the HR senior manager and the Workforce Advancement and Training manager. The HR senior manager indicated that in September, this organization will change, and the senior manager will supervise the HRCs. Mercer believes that HRCs and the Workforce Advancement and Training manager (and training staff) should report to the senior HRM to give the organization clarity in terms of lines of accountability.
- DASA has assigned HR responsibilities to one AA5, although interviewees indicated that these responsibilities should be handled by a position at the HRC level. Mercer agrees.
- MHD has one full-time HRC position and a partial WMS position devoted to HR. The HRSA senior manager has begun to get involved in assisting MHD with HR issues and reports that there are a number of serious situations at present, and many long untended HR issues. The HRSA senior manager reports no involvement with DASA HR issues at this time.
- HRMs and HRCs are assigned to the MHD state hospitals; these positions report to the HR Division at DSHS. Currently, it appears that HR issues at MHD headquarters require more immediate attention than at the state hospitals. However, Mercer believes that HRSA must have some degree of responsibility for HR staff assigned to the MHD

hospitals to ensure that HRSA HR policy directions are consistently adhered to, and that the shared services model applies across all Divisions.

- The HR senior manager states that his workload is at capacity and he will require an additional HRC3 or an additional HRC1 position to assist him.
- The senior manager reports that the current HRCs are serving 200-250 employees each at this time, and the Deputy Assistant Secretary requested that Mercer provide information on common HR-to-staff ratios. Common national norms suggest a ratio of one full-time HR representative to 100 employees, although this ratio may vary by the size of an organization. (A 2003 study in Texas showed that state agencies with 500 or more employees had HR-to-staff ratios ranging from 1:38 to 1:97, with the average at 1:58. The study recommended that all state agencies with 500 or more FTEs adjust their HR staffing to meet an HR-to-staff ratio of at least 1:100, however.)¹ As a result of the merger of the nine divisions included in the realignment, HRSA estimates that the administration will now comprise approximately 4,100 employees – although the majority of MHD employees are located at the state hospitals. Mercer cautions that common norms are useful benchmarks, but that each organization is different. HRSA will need to match its HR resources to its unique staffing needs and to respond to the significant changes underway as a result of state personnel reform. Thus, we recommend that HRSA conduct a careful analysis of its changing HR requirements and use the results of that analysis as a basis for determining an appropriate ratio of HR staff to employees.

Mandatory Training

Mandatory Training was also identified as a concern from interviewees.

- The senior manager indicated that HRSA has worked hard to increase its compliance with State mandatory training requirements over the past year, and is showing very good progress based on recent measurements.
- As a result of the merger of the nine divisions included in the realignment, the ratio of HR workforce planning and training staff to employees should also be evaluated. HRSA requested information regarding training staff to employee ratios for government programs. According to a study conducted by the State of New Mexico, an American Society of Training and Development (ASTD) survey in 2002 suggests that a benchmark for trainer to employee ratio in the government sector is one trainer for every 584 employees. If the trainers do not perform routine HR functions, they should not be included in the overall HR resource assessment. Thus, if the ASTD benchmark is applied, HRSA would require a staff of approximately seven HR trainers for 4,100 employees.² However, Mercer recommends that HRSA conduct a thorough analysis of training required to support the realignment. We recommend that HRSA base allocation of any additional workforce planning/training staff on the results of this analysis, relying

¹ See <http://www.window.state.tx.us/etexas2003/gg11.html>

² See <http://www.governor.state.nm.us/perfreview/Ch6.pdf>

on relevant benchmarks such as the American Society of Training and Development (ASTD) as a useful point of reference rather than a mandate.

- Overall, Mercer believes that centralized coordination and management of mandatory training would benefit HRSA, MHD and DASA in assessing needs and ensuring compliance.
- We recommend that the Manager for Workforce Advancement take responsibility for oversight of mandatory training at the state hospitals, and begin to collect training completion statistics from the MHD and DASA Divisions as well as the existing HRSA Divisions.

Managing Personnel Reform

Managing personnel reform is an immediate need, and change management will be a challenge, especially for MHD.

- HR must facilitate the transition and participate in developing communication strategies and driving the cultural change that has to occur for the realignment to be successful and for the successful transition to a new labor relations arena.
- In particular, HR must prepare for the new master agreement. Interviewees indicated that this will be significant and raises a need for re-training across all levels of staff in new approaches to key functions such as hiring, performance management, termination, and general labor management relations. HR staff will need to be fluent in understanding Collective Bargaining Agreements and supervisors will need to be adept at administrative changes driven by civil service reform. A shared services approach should facilitate maximizing existing resources to managing this important reform initiative.

HR Metrics, Data Collection and Tracking

HR metrics, data collection and tracking are also seen as key issues, particularly in light of the Governor's emphasis on accountability driven leadership through the Government Management, Accountability and Performance (GMAP) initiative.

- MAA is currently tracking vacancies and turnover. HRSA should begin collecting similar data for MHD and DASA under a shared services model, and begin to measure additional HR metrics such as recruitment turnaround time and responsiveness to other HR customer service issues.
- A shared services model should also include the state hospitals; although Mercer acknowledges that there are important features unique to the institutional environment. Of note, the HRSA senior manager has experience working in hospital HR functions, and could be an important resource for the institutions.

Mercer recommends using a shared services approach, and centralizing HR metrics, data collection and tracking to enable maximum efficiencies and compliance with this effort.

Co-Location

The physical dispersion of HR staff presents another concern. HRSA HR staff should be co-located in order to standardize HR services, ensure consistent practices, maximize use and backup of resources, and simply consolidate large files. Space is already anticipated to be at a premium (before construction of the new building is even completed), and the senior manager suggests that HR co-locate staff in one of the existing buildings, sparing the available new office space for other functions. As noted earlier, some degree of oversight of the HR staff in the state hospitals will be needed, although it is recommended that these staff continue to reside at the institutions.

Management and Supervisory Training and Succession Planning

Management and supervisory training and succession planning efforts are underway at HRSA via a written succession plan, public management training and certification for selected managers, and an initiative to implement a supervisory academy (in concert with ESA and Children's Administration).

- The extent to which similar endeavors exist at MHD and DASA is unclear, but the need is evident. At MHD, due to the turnover of senior and middle management positions, it will be important to develop a succession plan.
- The search and appointment of the Division Director and Deputy Director positions provides an opportunity to identify management and supervisory training needs.
- Given the long term tenure of the leadership at DASA, it will be important to assess the internal management and supervisory needs with the goal of succession planning. Here again, centralization and adoption of a shared services model for HR services would offer distinct benefits to MHD and DASA to ensure that these key initiatives are addressed.

Consistent Policies and Practices

Deployment of consistent HR policies and practices is a recurring theme alluded to in the issues described above.

- Interviewees indicated that the DSHS/HRD-level centralization model is ineffective, and that while centralized policy making is necessary, policy and practices should be deployed via a distributed model. This would allow HRSA to take an enterprise-wide approach to coordinating not only with HRSA, MHD and DASA, but across other agencies as well (e.g., state hospitals, DD, Juvenile Rehabilitation).
- Mercer recommends centralizing HR services in a single location, sufficiently staffing the function, attaining some degree of oversight of HR staff located at the state hospitals, and organizing for clearer lines of accountability to support deployment of consistent HR policies and practices.

Organizational Visibility for HR

Emphasis on HR was raised by other staff interviewed; in particular, it was suggested that under the realignment, the title of the unit in which HR resides clearly identify the HR function (rather than being contained within a division titled “Legal Services”). The reason for this is to ensure the visibility of, and emphasis on HR throughout all levels of the organization. Mercer believes this is a relevant suggestion. A separate HR office could report to the Office of the Assistant Secretary to provide visibility.

LEGISLATIVE AND GOVERNMENT RELATIONS

OVERVIEW

The proposed HRSA organization establishes a legislative and government relations within the Office of the Assistant Secretary to manage legislative affairs for the former MAA, DASA and MHD and relations with other governments and government agencies. Currently, staff from DASA and MHD tracks all legislative inquiries, researches issues, and provides responses to legislative relations staff at DSHS, as well as coordinates with other government agencies and the Tribes.

FINDINGS AND RECOMMENDATIONS

This shared services model provides an opportunity to have a single tracking system of legislative inquiries and bill analysis, and to prioritize needs and initiatives within HRSA, including development and publication of rules and regulations. It will also assist the Tribes by having one representative for all HRSA divisions. However, the Medical Benefits & Care Management Division, DASA and MHD will still need to research and respond to program and regulatory issues, thus this organization will not necessarily result in staffing efficiencies.

DSHS legislative and government relations staff may also need direct access to HRSA divisions to expedite information processing during peak legislative activity. Further, because the Legislature has various committees that address topical matters (e.g., Mental Health Task Force), there may need to be direct communications between staff within the divisions and the Legislature. It will be important for HRSA and DSHS to promote access to legislative inquiry, yet, maintain the appropriate boundaries between the Legislature and the Administration. Thus, an important role of HRSA's legislative and government relations staff will be to assist the divisions with the focus and scope of direct communications with legislature and other government agencies.

The Legislative and Government Relations manager could also serve as a senior policy advisor to the Assistant Secretary's Office, working on selected policy matters and special projects.

COORDINATION OF BENEFITS

OVERVIEW

Mercer's interview to discuss Coordination of Benefits (COB) focused on the potential for shared services opportunities with MHD and DASA around COB and third party liability (TPL) investigations. Interviewees agreed that MAA, MHD, and DASA would benefit from a better understanding of each others' COB/TPL requirements, and that the new MMIS presents opportunities for cross-divisional support and collaboration, such as helping RSNs and mental health centers identify Medicaid eligibles with other insurance. Even before the new MMIS is implemented, MAA can share expertise and information on Medicaid clients with MHD and the state hospitals. MAA, MHD, DASA, the state hospitals and the RSNs should be encouraged to work together and learn from one another, perhaps in the context of a project to identify shared COB/TPL opportunities.

FINDINGS AND RECOMMENDATIONS

Leveraging Resources Across HRSA

- MAA identifies clients with other health insurance and moves them out of managed care and into the FFS system in order to conduct TPL recoveries. MAA does not conduct TPL recoveries on MCO clients.
- MHD does not conduct non-institutional TPL recoveries. Rather, RSNs have financial incentives to maximize reimbursement by conducting these functions, and both providers and the RSNs tend to focus on dual eligibles. Staff noted that unlike MAA, the MHD RSNs do not have a FFS option, so it does not appear that MAA's current function has a potential direct link to the RSNs.
- Staff also noted that there would be significant stakeholder resistance to efforts by HRSA to conduct TPL recoveries from the RSNs, as the mental health system is significantly under-funded to begin with. HRSA is also several transactions removed from this function when it comes to the RSNs. The RSNs receive capitation payments from the state; in turn, they use these funds to reimburse mental health center providers. TPL recovery would occur at the mental health center (provider) level. Additionally, the mental health providers tend to be small, unsophisticated organizations that may lack the skills, resources, or time to devote to this function.
- The state hospitals, however, are direct purchasers, and would conduct COB/TPL functions similar to other hospitals. Staff indicated that the hospitals should continue to handle this function internally, rather than attempt any centralization within HRSA.
- DASA does no TPL recovery. DASA programs are mostly local, and funding is provided to the counties or specific providers under purchased services contracts, so there is no TPL opportunity.

- The new MMIS may present opportunities for cross-divisional support and collaboration on COB/TPL efforts. With the new MMIS, RSNs will be able to research other health insurance status of their Medicaid clients – of course, not all their clients will be Medicaid-eligible. Nevertheless, HRSA could provide assistance to the RSNs and mental health centers in identifying those Medicaid eligibles with other insurance.
- At this point, no specific discussions, other than applications development sessions for the new MMIS, have occurred.
- Before the new MMIS is implemented, MAA should share information and expertise with MHD, and undertake joint discussions to determine whether collaborative opportunities around COB/TPL investigation exist.
- MAA should also approach the state hospitals to explore opportunities to assist them by providing available information on Medicaid clients.

Organizational Alignment of COB and the Medicare Buy-in Unit

Under the proposed re-alignment, the COB function, which plays a significant role in program cost avoidance, would be moved out of the MAA Division of Customer Support (which becomes the HRSA Division of Eligibility & Service Delivery) and under the new Division of Finance & Rates Development. This change continues the separation of COB from Claims and is supportive of creating a check and balance to ensure Claims is capturing all appropriate COB information.

- Mercer notes that the proposed re-alignment also places the Medicare Buy-in Unit (MBU) in Finance & Rates Development. Some interviewees suggested that the MBU would more appropriately remain with the Division of Eligibility & Service Delivery. The MBU handles all work related to the Medicare program and its interface with the Medicaid program. This work occurs in three key areas: Medicare eligibility, Medicare recoveries, and eligibility research related to Medicare Advantage Plans under Part C:
 - *Medicare Eligibility:* The MBU manages the Medicare buy-in process, which entails working closely with field offices for the Economic Services Administration and the Aging and Disability Services Administration to accurately identify and track client eligibility; process data from CMS and SSA electronic interfaces to update Medicare eligibility; and assure correct payment of Medicare premiums for low-income Medicare clients.
 - *Medicare Recoveries:* The MBU identifies periods of Medicare retro-eligibility, and if MMIS paid claims for those periods, initiates a process to recover those amounts and instruct the provider to bill Medicare.
 - *Medicare Advantage Plans:* The MBU must research eligibility for Part C and, upon client request, pay associated coinsurance, co-payments and deductibles.
- Determining Medicare eligibility is very complex due to multiple and often conflicting federal data sources, and the MBU must work closely with field offices in several arenas, including modifying inaccurate Automated Client Eligibility System (ACES) data,

making required eligibility changes, responding to inquiries from the field offices, and resolving issues involving inaccurate Medicare premium deductions.

- In contrast, the recoveries function appears to be somewhat more straightforward. Twice each month, CMS sends DSHS the Buy-In file which provides information about Medicare eligibles. The MBU also identifies eligibles for the recoveries process, work that entails identifying periods of retroactive Medicare eligibility during which the MMIS paid claims which now must be recovered; generating letters to providers regarding client (retro) Medicare eligibility and instructing the provider to reimburse Medicaid and bill Medicare directly; complying with provider dispute hearing requirements; and coordinating recoupments with Claims.
- Eligibility determination related to Medicare Part C requires MBU staff to research eligibility for Part C, determine whether to pay a premium, if required, for the Part C plan; and, (in accord with Federal rules) upon client request, paying associated coinsurance, co-payments and deductibles for Part C coverage, which often requires case management with field office staff and the client to assure these amounts are correctly paid.

Thus, the MBU's most complex tasks appear to be eligibility research, which in turn drives the recovery process. Under the realignment, HRSA has consolidated payment review functions under the Division of Systems & Payment Review. To maintain this approach, Mercer recommends that HRSA split the recovery functions out of the MBU and place them in the Division of Systems & Payment Review while retaining the more complex eligibility determination functions with the Division of Eligibility & Service Delivery. The MBU's heavy emphasis on eligibility determination makes a good case for placing these functions with the eligibility area, and this functional split offers an additional check and balance between Divisions.

INFORMATION TECHNOLOGY

OVERVIEW

Although MHD, DASA, and the divisions within MAA currently operate different information systems and have some unique business needs and challenges, Mercer believes that IT management across the divisions must be collaborative and integrated, and that a move toward immediate integration of project management and resource prioritization, among other functions, would benefit the divisions.

Integration should occur on a staged basis, with the ultimate goal of merging into a single service entity. The MMIS Reprourement Project represents one vehicle for moving toward greater integration and shared payment and decision support systems.

Further, Mercer recommends that the HRSA Assistant Secretary establish a policy direction and sponsor efforts to achieve a single, consolidated IT service delivery organization, which would pave the way for the Divisions to work together to achieve this end. IT leadership at each division must achieve a better understanding of each division's IT organization, rules, resources and infrastructure and work together to achieve certain common goals as described in the following sections.

FINDINGS AND RECOMMENDATIONS

Under the proposed HRSA organization, the MAA IT functions reside in the Division of Systems & Payment Monitoring. MHD and DASA IT functions reside within each of those divisions and each of the state hospitals also have their own IT support functions. MAA, MHD, and DASA use a number of different automated information systems, including:

- the Medicaid Management Information System (MMIS),
- the Social Service Payment System (SPSS),
- Target (the DASA case management system),
- the Performance Based Prevention System (PBPS, hosted by a DASA contractor),
- Conman (the DASA in-house contract management system);
- the MHD Client Information System (CIS); and
- the State Hospitals Integrated Patient Information System (SHIPS), the information system used at the State's two psychiatric hospitals and the Child Study Treatment Center (in project planning phase).

Pertinent Findings by Division

MHD

- Mercer's earlier study of MHD identified a number of weaknesses in the MHD IT infrastructure that must be resolved in order for MHD to assume legislatively mandated responsibilities for oversight of the RSNs. These were outlined in our earlier report. At the conclusion of that assessment, Mercer suggested several major changes; however,

these recommendations preceded the decision to move MHD and DASA into the HRSA organization.

- Rather than develop new system functions and features for MHD, it was suggested that as an interim approach the MMIS could be modified to help support MHD's requirements. For example, MAA and MHD have had discussions to determine whether the RSNs could submit encounter data through the current MMIS. MHD uses the standard 837 claim transaction for encounter data and uses similar (though fewer) data elements, so this appears feasible. However, the issue of encounter data for non-Medicaid clients is more significant, and it is unclear whether those encounters could be linked to the 820 (Premium) and 834 (Enrollment) transactions to identify state only clients. That is not seen as an insurmountable issue, but would require further exploration.
- Complicating this approach, the current MMIS is close to capacity in terms of modifications, and further changes to it involve escalated risk. The current MMIS also does not offer a complete test environment.
- The current MMIS is being replaced with a new system. Existing MMIS functions (including existing MHD functions) will transfer to the new system and are slated for implementation in July 2007. A second phase of functionality will be implemented in 2009. MHD has been involved in developing requirements for the new MMIS; so that is a positive finding, yet won't resolve the immediate MHD IT predicament.

MAA

- The integration of MAA IT with MHD and DASA presents an opportunity for leveraging resources, but there are challenges. Foremost, the divisions currently lack an in-depth understanding of each other's business requirements. However, if integration were feasible, benefits include:
 - improvements in the maintenance and development of applications;
 - commonality of desktop applications and hardware;
 - consistent adherence to standards and enterprise resource planning (ERP) architecture principles;
 - HIPAA compliance; and
 - potential gains through economies of scale.
- MAA has a large and effective IT infrastructure, and has developed expertise and tools that could be of benefit to MHD and DASA under a more integrated infrastructure.
- Caution must be exercised however, and the divisions need to assess each other's resources, functions, and technology. Poorly planned integration efforts might lower the level of services across divisions rather than raise capabilities.
- MAA has adopted Enterprise Resource Planning (ERP) rules. To support a single service IT approach, compliance with a universal set of boundaries would be necessary.
- MHD may not be fully cognizant of opportunities to leverage the MMIS, and the SHIPS independent development project would perpetuate this.

- MAA acknowledges weaknesses in the area of project management and prioritizing customer requests. MAA is currently developing a project management organization and policies and procedures to support prioritization of service requests. MAA has drafted a policy for review by HRSA executives, which if adopted will establish an IT Steering Committee. Mercer believes that a solid project management discipline and service prioritization must be in place to support IT integration.

DASA

- Key DASA IT concerns relative to the realignment include the desire to maintain accessibility to IT services and speedy response. However, interviewees acknowledge potential benefits to sharing expertise and access to data, collaborating around common clients and common issues, and around planning and service delivery, care coordination and research.
- DASA business needs differ from MAA or MHD in that DASA uses FFS and formula-driven reimbursement. Twenty percent of DASA services are for Medicaid clients/reimbursed via the MMIS. There are differences in service delivery, provider rates and financial solvency, and measures of provider accountability; and the crossover of providers with the MAA and MHD may be low.
- Currently DASA is on a different platform and uses a web-enabled system run through its own servers. DASA IT systems/functionality includes:
 - Target, an in-house a case management system;
 - Functionality for matching State Patrol records to assess post-treatment criminal activity;
 - Conman, an in-house contract management system that interfaces with the Agency Financial Reporting System (AFRS, the state financial system) for payment.
- DASA IT support initiatives on the horizon include:
 - compliance with HIPAA National Provider Identification (NPI) regulations (a change that will be common across all programs);
 - IT support for a new gambling addiction program;
 - the need to re-design five older systems that support certification of chemical dependency programs into a single application;
 - migrating Target from Microsoft Visual InterDev to .NET; and
 - implementing Software Management Services (SMS) in the network over the next six months to manage patches and upgrades (MAA has already implemented SMS for its environment).

IT Recommendations

Mercer recommends that the HRSA Assistant Secretary establish a policy direction and sponsor efforts to achieve a single, consolidated IT service delivery organization, which would pave the way for the Divisions to work together to achieve this end. The goals of this effort include:

- sharing/leveraging expertise, resources, and technology;
- adopting standardized practices, including a Project Management Office (PMO) governance body;
- creating the conceptual design of a “to be” unifying enterprise architecture; and
- creating the conceptual design of a multi-division integration framework (possibly based on the Publish/Subscribe paradigm).

This is the first step toward defining the feasibility and extent to which a shared services approach could be adopted. It is clear from the interviews that data sharing is a common interest, as is adopting a unified approach to common client issues.

Given the realignment, Mercer recommends that HRSA reassess the recommendation to implement a new system for MHD if there are opportunities to leverage resources across divisions. However, it will be critical for HRSA to identify a budget to improve MHD’s IT capacity and funds to continually upgrade the IT infrastructure.

Further, Mercer recommends that HRSA re-evaluate work in progress to replace SHIPS. It is Mercer’s understanding that work is underway to design this replacement system although the funding source for this effort is undefined. IT investments such as system replacements are large and costly endeavors, and decisions regarding any system development should be made in light of the HRSA enterprise and at the top levels of the administration.

Mercer recommends a staged approach, and that IT integration with the State Hospitals be explored separately.

IT Integration Priorities

The recommended phased approach should have the following integration priorities:

- As the first priority, IT support for MHD (non institutional functions) must be addressed.
 - MAA has already begun to explore using the current MMIS to support MHD, and this effort must be accelerated to resolve issues around RSN encounter data submission and reporting.
- DASA IT support should be the second priority.
 - There appear to be opportunities for increased data sharing; for leveraging the expertise of MAA to support future IT and business initiatives; and for common initiatives focused on planning and service delivery, care coordination, research,

utilization management, reducing fraud and abuse, and client risk assessment and evaluation.

- IT support for MHD institutional functions should be the third priority.

To lay the foundation for this expanded integration, Mercer also recommends strengthening divisional business analysis resources to broaden the divisions overall understanding of business requirements and identify opportunities for mutual collaboration, leveraging resources, and in generating the breadth and depth of process knowledge, data, system requirements, and impacts so crucial for sound project understanding, direction, and decision-making.

Further, Mercer recommends moving toward early integration of certain IT functions:

- integrating project management and governance;
- defining and managing systems security from an enterprise perspective; and
- implementing and maintaining HIPAA compliance (e.g., the NPI regulations) centrally.

These are areas where more centralization and standardization makes sense, as well as collaboration on evaluating enterprise-wide architecture decisions. These IT functions should be considered from a shared services model perspective. Success in integrating these functions will contribute to improved communication and collaboration as well as additional, more robust integrations in future phases. However, the divisions must first become fluent in understanding each other's resources, business needs, strengths and weaknesses.

Finally, Mercer recommends that the HRSA Assistant Secretary assure that an adequate budget is secured to support the IT integration effort. Sound financial planning and budget predictability are essential in assuring that the IT infrastructure supporting the divisions is maintained, updated, and able to grow with the needs of the divisions.

STATE HOSPITALS

OVERVIEW

Currently, the state hospitals are within the MHD. Each of the CEOs of the hospitals reports to the MHD Director (position currently vacant). There is virtually no integration with HRSA.

FINDINGS AND RECOMMENDATIONS

It makes sense to continue having the state hospitals reside within the MHD. Delivery of clinical care and daily operations should be the primary focus of hospital management. However, for functional areas such as finance, IT and HR, there should be reporting relationships to the functional leads within HRSA. Moreover, there are opportunities for shared services.

- For the State Hospitals, utilizing certain shared services in the finance related areas should result in the opportunity for efficiencies and better integration of budgeting and fiscal monitoring activities. The nature of the operations of the State Hospitals is different however, so Mercer would recommend implementing shared services first for all other programs within HRSA, as discussed previously in this report, and then begin to implement shared services, where appropriate, for the State Hospitals.
- As an interim step, Mercer would recommend that there be a direct line of accountability from the hospital CFO to the Director of the Division of Finance & Rates Development. This will ensure fiscal operations are appropriately managed within the context of the broader HRSA organization and simplify budgeting and other fiscal interactions with DSHS.
- Human Resources (HR) management should remain within the facilities; however, HR staff should follow HRSA HR protocols and requirements and also have a direct line of accountability to HRSA HR to address HR standards and requirements.
- Each hospital's Quality Management function should identify QM goals and priorities that are consistent with the larger HRSA quality strategy. MHD should include hospital QM goals in its portion of the HRSA QM plan and these should be reviewed by the HRSA Quality Management Committee.
- As mentioned previously, it is important to maintain communications staff at the state hospitals to address local issues resulting from the hospital's employment policies and patient care (e.g., patient elopements, publicity about hospital work programs, etc.). Yet, communications staff should have a direct line of accountability to the HRSA communications office.
- Legislative Affairs and Government Relations should be addressed through MHD and the HRSA communications office, with guidance from the facilities on local issues.
- For facility information systems, similar to finance, Mercer recommends that shared services be implemented first for other programs within HRSA, but there should be a direct line of accountability to the HRSA Division of Systems & Payment Monitoring.

MHD OTHER SERVICES REVIEW

OVERVIEW

This section of the report focuses on MHD functions that are more specialized than those previously discussed. There are three main areas:

- Administration Functions
- Services and Planning
- Functions Specific to MHD

Administration Functions: In the oversight of MHD, the previous Administration rolled down many of the administration-level functions to both DASA and MHD. As a result, there are several functions that could be managed at the HRSA administration level.

Note: While Mercer did not have the opportunity to review these same functions within DASA, some of the recommendations below may apply to DASA as well.

Services and Planning: MHD manages oversight of a substantial amount of state-funded services that have different requirements from Medicaid services. The state-funded services encompass recovery-based services and special initiatives that result from stakeholder advocacy. MHD contracts for these services through the RSNs. The Request for Qualifications (RFQ) that will be released to existing RSNs on October 1, 2005 includes these state funded services as well as Medicaid services. MHD also manages federal grants and other state special initiatives.

Functions Specific to MHD: Finally, there are a number of functions that do not fit in well with a shared services model at this time and should be retained by MHD. It may be possible to develop a shared service approach in the future.

FINDINGS AND RECOMMENDATIONS

Shared Services Model

MHD staff discussed the functions that require special coordination with DSHS that could move to a shared services model. Some of these functions have already been discussed in previous sections, but it is worth noting that MHD staff participating in interviews concurs with the proposed organizational changes.

A table follows that lists the MHD function and the HRSA division or office that could address these issues:

| MHD Current Function | | HRSA Realignment Division or Office |
|--|---|--|
| ■ Fair Hearings | | |
| ■ Administrative Hearings | ⇒ | ■ Legal Services |
| ■ WAC/Rule Coordination | | |
| ■ Tribal Liaison | ⇒ | ■ Legislative and Government Relations |
| ■ Minority Affairs –Diversity | ⇒ | ■ HRSA Diversity Committee |
| ■ Limited English Proficiency Requirements | ⇒ | ■ HRSA Interpreter Services |
| ■ Medicaid Transportation | ⇒ | ■ HRSA Transportation |

Services and Planning

- State Mandates/Services
 - Mentally Ill Offenders
 - Dangerous Mentally Ill Offenders
 - Children’s Services Collaboration
 - Engrossed Second Substitute Senate Bill 5763 (ES2SB 5763)
 - Engrossed Substitute Second House Bill 1290 (ES2HB 1290)
- Federal Grants Management and Oversight
 - PATH Grant – procurement of about \$1.2 M resulting in grants of \$30-\$100K to RSNs
 - Block Grant – \$8M of which 80 percent goes to RSNs through a distribution formula in a block payment

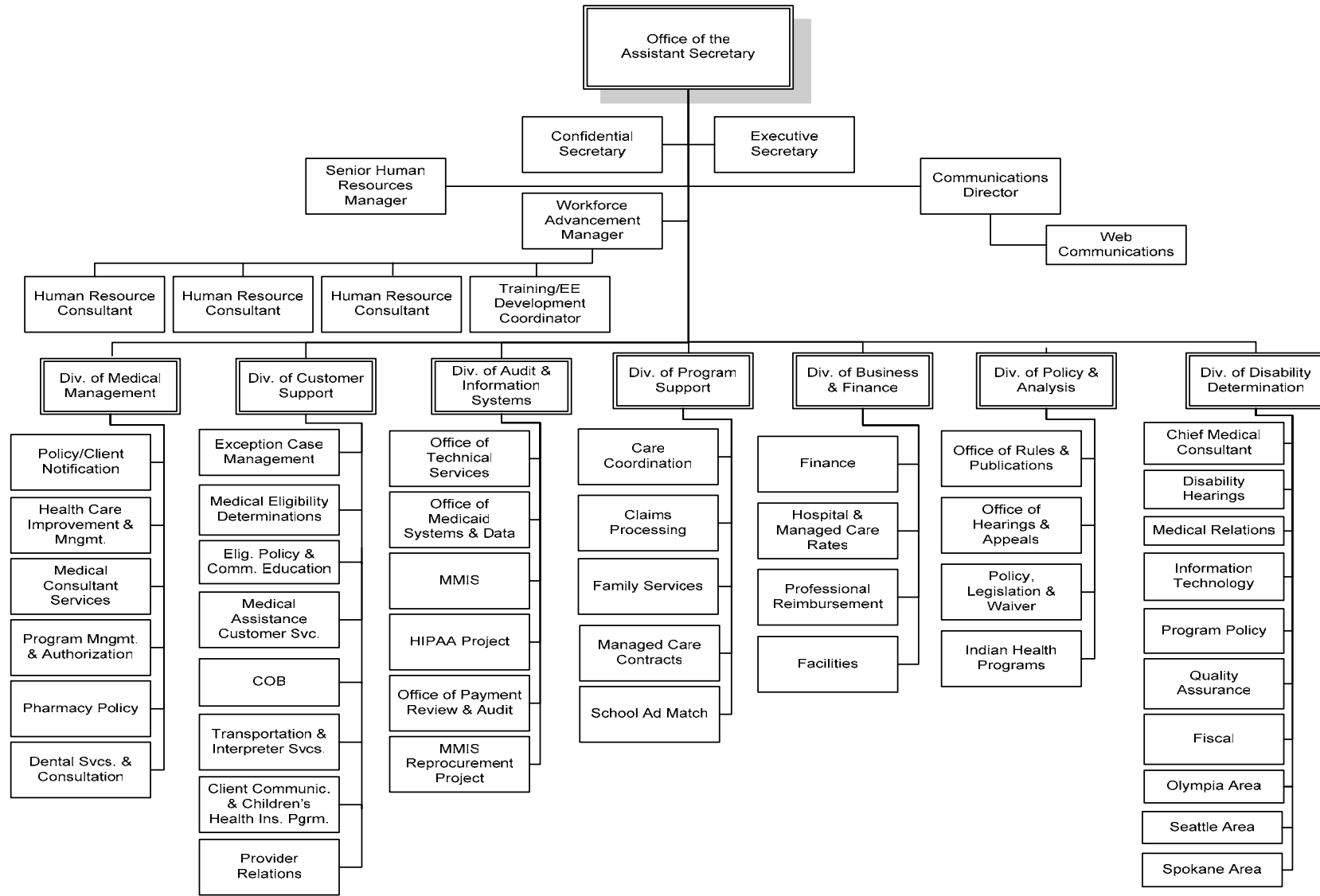
Functions Specific to MHD

- Licensing of mental health agencies and certification of RSNs: Licensing is an important function that establishes minimum criteria for participation as a provider of Medicaid and state-funded services. (RSN certification may be phased out due to the procurement requirements for RSNs stipulated in ES2HB 1290). Licensing and quality assurance functions are now combined. (Mercer recommended separating these functions in the Mercer May 2005 report on MHD operations.)
- Consumer Affairs: Currently, MHD has a Consumer Affairs Office that is an important focus of implementing the requirements of ES2HB 1290 and the principles of recovery. (In Mercer's May 2005 report, it was recommended that MHD provide more visibility and authority for this office by having it report directly to the MHD Director.)
- Family and Parent Involvement: MHD will need to continue its collaboration and involvement of parents and family members of individuals with serious emotional disturbance and mental illness. While it may be useful for HRSA divisions to share strategies for family/parent and stakeholder involvement, it is important for families and stakeholders to have direct access to MHD.
- Washington Institute for Mental Illness Research and Training Contract, University of WA. MHD currently has a contract to assist with research and data management of service information. This is a necessary function that can support quality management; however, Mercer recommends the efforts of this contractor should be coordinated with data available from Systems and Payment Monitoring Division.
- While MHD staff recommend transfer of consumer complaints to a centralized HRSA level function, it maybe important for consumers to have direct access to MHD to resolve complaints that have not entered the formal grievances, appeals, and fair hearings process. This recommendation requires additional review.

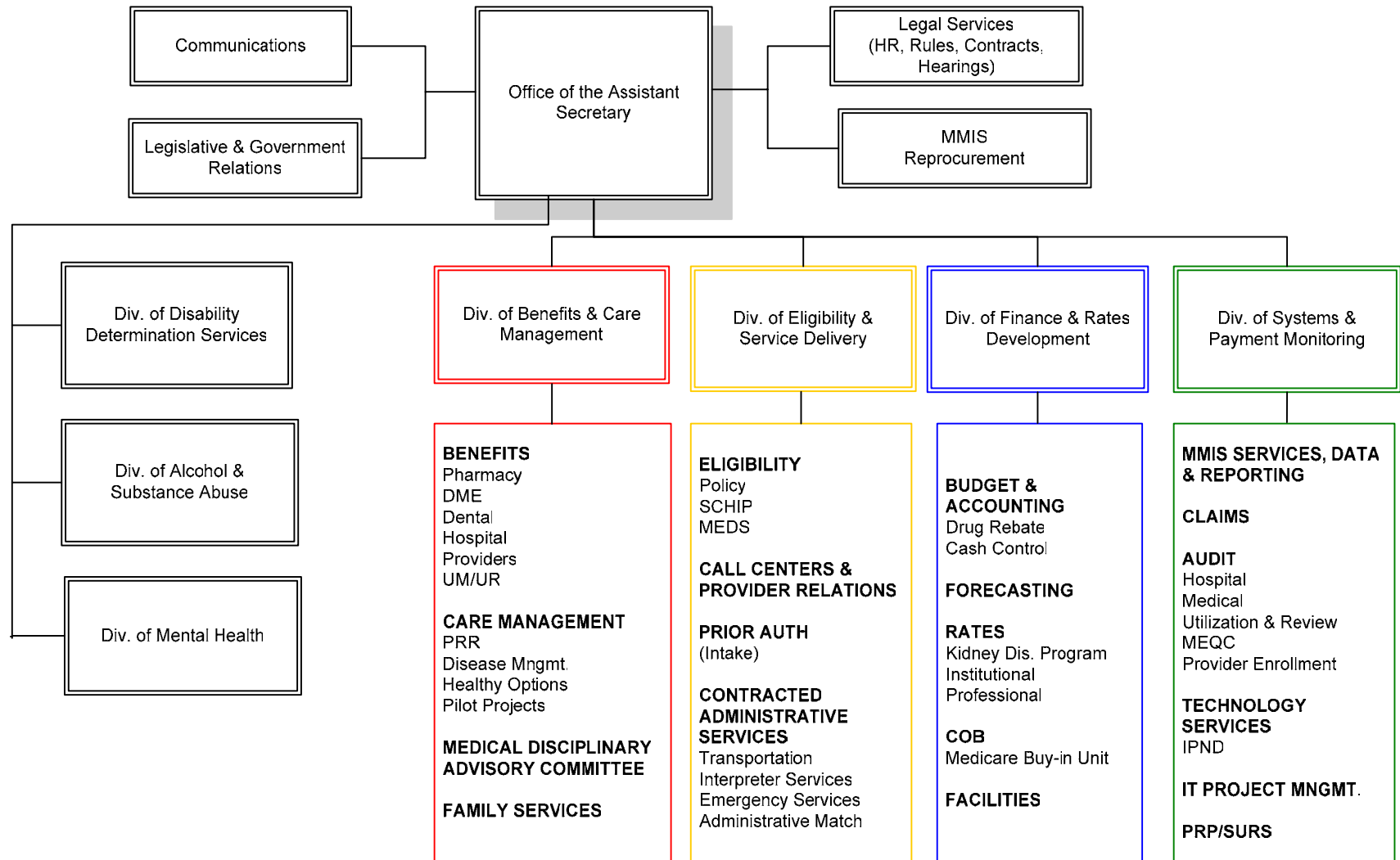
APPENDIX 1: INTERVIEW SCHEDULE

| Date | Subject(s) | Mercer Consultants |
|-----------|---|--------------------------|
| August 9 | <ul style="list-style-type: none"> ▪ In Depth Entrance Interview | Davis, Melton, Sternbach |
| August 9 | <ul style="list-style-type: none"> ▪ Managed Care ▪ Procurement ▪ Contracts Management ▪ CMS Audit Findings ▪ MH Reform Expectations | Davis, Sternbach |
| August 9 | <ul style="list-style-type: none"> ▪ Information Technology | Melton |
| August 9 | Legal: <ul style="list-style-type: none"> ▪ Contracts Management ▪ Client/Provider Disputes & Hearings | Sternbach |
| August 9 | <ul style="list-style-type: none"> ▪ Information Technology | Melton |
| August 9 | <ul style="list-style-type: none"> ▪ Communications | Sternbach |
| August 9 | <ul style="list-style-type: none"> ▪ Legislative Relations | Sternbach |
| August 10 | <ul style="list-style-type: none"> ▪ Budget and Finance ▪ Rate Setting ▪ Accounting ▪ Forecasting | Davis |
| August 10 | <ul style="list-style-type: none"> ▪ Audit and Monitoring | Melton |
| August 10 | <ul style="list-style-type: none"> ▪ MHD Other Services Review | Sternbach |
| August 10 | <ul style="list-style-type: none"> ▪ Third Party Liability ▪ Coordination of Benefits | Melton |
| August 10 | <ul style="list-style-type: none"> ▪ Human Resource Organization | Melton |
| August 11 | <ul style="list-style-type: none"> ▪ HRSA Exit Interview | Team |

APPENDIX 2: CURRENT MAA ORGANIZATIONAL STRUCTURE



APPENDIX 3: PROPOSED HRSA ORGANIZATIONAL REALIGNMENT



MERCER

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